

# REGISTRATION FOR LUPTON DERMATOLOGY AND SKIN CARE CENTER

## Patient Information

Last Name \_\_\_\_\_ First Name & Initial \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_  
Email Address \_\_\_\_\_ SS # \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Sex  M  F Marital Status  Single  Married  Divorced  Widowed  
Race \_\_\_\_\_ Ethnicity  Hispanic  Non-Hispanic Preferred Language \_\_\_\_\_  
Referred by \_\_\_\_\_ If Married, spouse's Name \_\_\_\_\_  
Patient's Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Guarantor Information

Relationship to Patient \_\_\_\_\_ If self, do not fill out information in this section.  
Last Name \_\_\_\_\_ First Name & Initial \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Sex  M  F Guarantor's SS # \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_  
Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_

## Insurance

**Insurance #1** \_\_\_\_\_ Employer \_\_\_\_\_  
Policy Holder's Last Name \_\_\_\_\_ First Name & Initial \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ SS# \_\_\_\_\_ DOB: \_\_\_\_\_  
Certificate # \_\_\_\_\_ Group Number \_\_\_\_\_  
**Insurance #2** \_\_\_\_\_ Employer \_\_\_\_\_  
Policy Holder's Last Name \_\_\_\_\_ First Name & Initial \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ SS# \_\_\_\_\_ DOB: \_\_\_\_\_  
Certificate # \_\_\_\_\_ Group Number \_\_\_\_\_

## Authorization to pay benefits to physician and to release information:

I hereby authorize the physician designated to release information acquired in the course of my treatment that is necessary to process insurance claims and collect payment for services provided. I hereby assign payment directly to Frederick A. Lupton, III MD PA for any medical/surgical procedures performed. I understand that I am responsible to pay of all charges incurred by the patient listed above. It is my responsibility to know what services/procedures are covered under my insurance plan. If my insurance decides treatment is for any non-covered services, cosmetic services or services requiring pre-authorization which I did not obtain, I will be responsible for payment. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

06-11

# DERMATOLOGY MEDICAL HISTORY

Patient: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

**Preferred Pharmacy:** \_\_\_\_\_

(Street Address) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_

Yes Are you allergic to any medications? If yes, list below: \_\_\_\_\_  No

Yes Have you ever had a reaction to numbing medications? \_\_\_\_\_  No

List all medications you are currently taking (including prescriptions, over-the-counter, vitamins and herbs)

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_  see attached list dated \_\_\_\_\_

Please list any medical conditions or surgeries of which we should be aware:

## Skin:

- Yes No  Do you sunburn easily?
- Yes No  Have you ever had abnormal moles?
- Yes No  Have you ever had skin cancer?
- Yes No  Has anyone in your family had abnormal moles?
- Yes No  Has anyone in your family had skin cancer?
- Yes No  Do you have a history of any specific skin diseases?  
If yes, \_\_\_\_\_
- Yes No  Do you have problems with healing?
- Yes No  Do you develop keloids (scars) after surgery?
- Yes No  Do you bleed easily?
- Yes No  Do you develop skin rashes in reaction to  Medications  Food  Environment  Bandages  
 Poison Ivy  Jewelry  Topical Neosporin  Other \_\_\_\_\_

## Social History:

- Yes No  Do you drink alcohol?
- Yes No  Do you use IV drugs?
- Yes No  Do you smoke?
- Yes No  Have you had or have you been exposed to HIV (AIDS) ?
- Yes No  Have you had or have you been exposed to hepatitis?
- Yes No  For women only, are you pregnant? Due Date \_\_\_\_\_

Completed by:  Patient

Medical Assistant \_\_\_\_\_  
Initials

Signed by patient \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

L U P T O N  
**DERMATOLOGY  
 & SKIN CARE**  
 C E N T E R

Thank you for letting us serve you. To acquaint you with our billing and insurance policies, please read the following information and sign below.

**You are responsible for co-pays, deductibles, non-covered services, co-insurance, all balances and any services considered not medically necessary by your insurance company. Payment is expected at the time of service.** It is your responsibility to know your deductible status and what procedures are not covered by your insurance plan.

Here is a list of the majority of our currently contracted insurance companies. There may be periodic additions or deletions to this list.

- |                        |                     |                               |
|------------------------|---------------------|-------------------------------|
| Aetna                  | Health Care Savings | Many Medicare Advantage Plans |
| AARP                   | Humana/Choice Care  | PHCS                          |
| Blue Cross Blue Shield | MedCost             | TriCare                       |
| Cigna/Great West       | Medicaid            | United HealthCare             |
| First Health           | Medicare            |                               |

If your insurance company is not listed, please ask us. We file with the majority of insurance companies. **If your insurance company requires a referral, please make sure you have proper documentation before coming to your appointment. Patients without proper referrals will be responsible for paying their balance in full when services are rendered.**

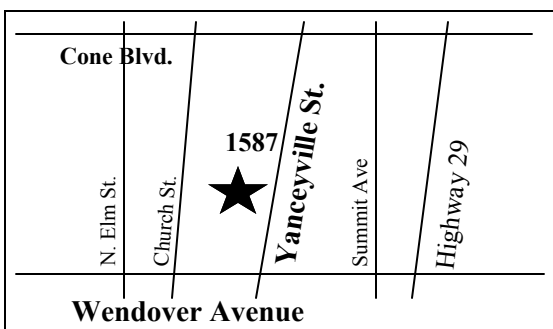
Please provide us with complete and up to date insurance information. If this information is not provided at the time of service we cannot file your claim and you will be billed. Remember, co-pays, coinsurance and deductibles are due when services are rendered. A statement fee may be applied to each date of service if above are not paid at time of service. If your account becomes delinquent, we may refer the account to a collection agency or attorney.

While there may be some exceptions, cosmetic and non-covered services are usually not reimbursed by insurance. If you have any questions regarding coverage for these services, we recommend that you speak with your insurance representative before the time of service.

All lab work, including pathology, is sent outside of our office. The lab we use, selected on the basis of quality and service, may or may not be part of your health plan. These charges are separate from ours, and they will bill you.

I have read and understand the above information. Please sign, date and return to our office.

Directions at [www.luptondermatology.com](http://www.luptondermatology.com)



\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

1587 Yanceyville St. Greensboro, NC 27405 / PO Box 14994, Greensboro, NC 27415  
 phone 336.271.2777 fax 336.273.1910

# Frederick A. Lupton III, MD, PA

## RECEIPT OF NOTICE OF PRIVACY PRACTICES Written Acknowledgement Form

Frederick A. Lupton III MD PA has a Notice of Privacy that states how the practice may use and release your health information.

The Notice is available for review on our website, [www.luptondermatology.com](http://www.luptondermatology.com).  
or you may read it in our office.

Please sign below to indicate that you (or your legal representative) have been offered the opportunity to review and/or receive our Notice of Privacy Practices and understand its terms.

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_